MISSOURI MC+

APPLICATION

MC+ is Missouri's health insurance program for **children under the age of 19, some parents, and pregnant women**. To apply, **complete and sign** the attached application and return it to the above address.

INSTRUCTIONS FOR COMPLETING THE MC+ APPLICATION

Section A - Mailing Address
Please provide your name, address, and phone numbers. Please indicate under "Message Phone Number" the number where you can be reached during regular work hours, or where we can leave a message for you.

Section B - Household Information
List all the children, parents, step-parents or guardians in the household, yourself first. It is important that you indicate the relationship of the person to you; i.e., spouse, son, daughter, etc. Race and ethnic group information is only for statistical use and is optional. The Social Security Number is required only for persons applying for MC+ coverage. Put an "X" in the last box to indicate you are applying for MC+ for that person.

Section C - Income
In order to determine your family's eligibility for MC+, please complete this section. Attach a sheet if more space is needed. **Please submit income verification, for the last 30 days, with the application.**

Section D - Insurance
For some applicants, eligibility for MC+ will depend on their access to health insurance. It is important that you complete this section. List all health insurance, regardless of source.

Section E - Absent Parent
Only complete this section if a parent of one of the children applying for MC+ is absent from the home. The law requires cooperation with Child Support Enforcement in obtaining payment for medical care. This means you must cooperate in identifying the absent parent, helping locate the absent parent, helping to establish paternity and other necessary action. Failure to cooperate does not affect your child's eligibility for MC+ coverage. Your eligibility may be affected if you fail to cooperate. Your cooperation may be of value to you and your child because it might result in finding the absent parent, legally establishing the child's paternity, and obtaining child support payments and rights to future Social Security, Veteran's, or other governmental benefits.

If you feel it is not in your child's best interest to pursue medical support from the absent parent, for example, past abuse or threat of abuse, check "yes" in Question #1. You may have "good cause" for not cooperating if your cooperation could result in physical or emotional harm to the child or to you. You will be asked to provide evidence to support your claim.

If you claim "good cause", by checking "yes" in Question #1 for not cooperating in obtaining medical support, you will be given a notice that will explain the circumstances under which good cause may be found, and the type of evidence or other information needed to decide your claim. You may also ask for this notice to help you decide whether or not to claim good cause.

Section F - Signature
Please read this section carefully and sign the form. **The effective date of MC+ coverage is based on the date your signed application is received.** Return the application to the above address.

Call 1-888-275-5908 if you have questions

Please keep this page. It contains important information.

OTHER IMPORTANT INFORMATION ABOUT MC+

If you have questions or need assistance completing the application, call toll-free **1-888-275-5908.**

When your application is received, it will be reviewed and if additional information is needed, you will be contacted. If you do not have a phone, you can contact us at the above phone number a few days after you mail the application.

You will be notified by mail when we have completed our review. For pregnant women, applications are processed within 15 days. All other MC+ applications are processed within 30 days. If you disagree with the decision concerning your eligibility, you may request a fair hearing within 90 days of the date of the decision.

INFORMATION NEEDED

The following information may be needed prior to approving your MC+ application:

- Income verification for the past 30 days (i.e. paycheck stubs, letter from employer, federal income tax return, award letter, etc.);
- Immigration documents showing name, immigration status, registration number and date of entry of those persons applying for MC+ who are not U.S. citizens; and
- Medical statement confirming pregnancy and expected date of delivery (if applying for MC+ as a pregnant woman).

If possible, send this verification with your application. We will accept copies of these items, however, if you send originals, we will copy them and return the originals with your notification letter. DO NOT DELAY SENDING IN YOUR APPLICATION IF YOU DO NOT HAVE THE VERIFICATION READILY AVAILABLE. You will be notified if additional information or verification is needed.

HEALTHY CHILDREN AND YOUTH PROGRAM

If your children qualify for MC+, they can receive services through the Healthy Children and Youth (HCY) program. HCY provides primary and preventive health care. Your child can get examinations, shots, and tests that help them stay healthy or identify medical problems that may require treatment. MC+ will pay for these health care services.

If you are pregnant and would like health risk appraisal and case management services, contact your local health department or call TEL-LINK (1-800-835-5465).

RIGHTS AND RESPONSIBILITIES

You must **report any changes in circumstances declared in the application statement within 10 DAYS** of when they happen, no matter what causes the changes. You have a continuing obligation to report and cannot wait until you are contacted.

Any information provided on the application is subject to verification by Federal, State, and Local officials. You may be denied benefits and/or be subject to criminal prosecution for knowingly providing false information. The crime of stealing or attempting to steal public assistance benefits of a value of seven hundred fifty dollars ($750.00), or more upon conviction, is punishable by imprisonment for a period not to exceed five years; or by confinement in the county jail for a period not to exceed one year; or by a fine not to exceed ten thousand dollars ($10,000.00), or both. If the value of the unlawfully obtained benefits is less than seven hundred fifty dollars ($750.00), the crime is a misdemeanor.

You are entitled to fair and equal treatment regardless of your age, sex, race, color, handicap, religion, creed, national origin, or political belief.

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MISSOURI MC+ APPLICATION

COMPLETE IN INK

FOR OFFICE USE ONLY
DATE APPLIED
DCN
ELIGIBILITY SPECIALIST/SUPV/LOAD

A. MAILING ADDRESS

NAME (FIRST, MIDDLE, LAST)

ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P.O. BOX NO.) | CITY, STATE, ZIP CODE | COUNTY

HOME PHONE NUMBER | WORK PHONE NUMBER | MESSAGE PHONE NUMBER

INSTRUCTIONS: Please answer each question completely. Attach an additional sheet if more space is needed in any section.

B. HOUSEHOLD INFORMATION (LIST ALL CHILDREN, PARENTS/GUARDIANS AND STEPPARENTS WHO LIVE IN YOUR HOME, YOURSELF FIRST.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE*/ SEX	HISPANIC Y/N	RELATIONSHIP TO PERSON a.	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	(X) APPLYING FOR MC+
a.			SELF				
b.							
c.							
d.							
e.							
f.							

*(1 - WHITE 2 - BLACK/AFRICAN AMERICAN 4 - AMERICAN INDIAN/ALASKAN NATIVE 5 - ASIAN 6 - NATIVE HAWAIIAN/PACIFIC ISLANDER)

1. Are both parents of all the children in the home? ☐ YES ☐ NO (If No, complete section E.)
2. Are all of the persons applying for MC+ U.S. citizens? ☐ YES ☐ NO If No, list the following information for persons applying for MC+ who are not U.S. Citizens: Name, immigration status and registration number, date of entry: _____
3. You may qualify for coverage of unpaid bills for medical services received in the past three months. Did any of the persons listed above receive medical services in the past three months? ☐ YES ☐ NO If yes, who? _____
4. Is anyone in your household pregnant? ☐ YES ☐ NO If yes, who? _____ Expected due date? _____
5. Is your net worth (Net worth is the value of everything you own minus any debt): ☐ less than $50,000 ☐ $50,000-$100,000 ☐ $100,000-$150,000 ☐ $150,000-$200,000 ☐ $200,000 - $250,000 ☐ above $250,000

   Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) _____

C. INCOME (Please attach verification; i.e. paycheck stub, note from employer, federal income tax return, award letter, etc.)

1. Are you employed? ☐ YES ☐ NO If yes, name of employer _____

   How much are you paid **before** taxes or deductions? $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly
2. Is anyone else in your home employed? ☐ YES ☐ NO If yes, who? _____

   Name of employer _____

   How much are they paid **before** taxes or deductions? $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly
3. Does anyone in your home operate their own business or are they otherwise self-employed? ☐ YES ☐ NO

   If yes, who? _____ Describe what type of self-employment (baby-sitting, farm income, other) and amount earned: _____ ☐ Weekly ☐ Monthly ☐ Yearly
4. Childcare costs may be an allowable income deduction for working families. Do you pay someone to care for your child?

   ☐ YES ☐ NO If yes, list names of children cared for: _____

   How much do you pay for childcare: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

CALL 1-888-275-5908 IF YOU HAVE QUESTIONS

5. Does anyone in your home receive other income (such as child support, alimony, Unemployment Compensation benefits, sick benefits, interest income, Social Security benefits, or other unearned income)? ☐ YES ☐ NO If yes, complete the following:

PERSON RECEIVING	WHO PROVIDES THE MONEY?	AMOUNT RECEIVED?	HOW OFTEN RECEIVED?

D. HEALTH INSURANCE

1. Does anyone in your home have medical, hospital insurance or Medicare? ☐ YES ☐ NO

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		☐ Doctor ☐ Hospital If limited coverage explain: _____
		☐ Doctor ☐ Hospital If limited coverage explain: _____

2. Has anyone in your home lost **or dropped** health insurance within the past six months? ☐ YES ☐ NO If yes, provide name(s), date and reason coverage ended. _____

3. Is health insurance available for any member of your family through an employer or other group membership? ☐ YES ☐ NO
If yes, name of employer or group: _____
Is the insurance available for: ☐ Self ☐ Spouse ☐ Children How much is the premium for the children? $ _____ per _____

4. Do any of your children have a medical condition that left untreated would result in the death or serious physical injury of the child?
☐ YES ☐ NO If yes, provide name(s) of child(ren) _____

5. Is a third party responsible to pay for any of your medical care? ☐ YES ☐ NO If yes, who? _____

6. Please refer to the income guidelines sent with the application. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.
1. $ _____ per mo. Company _____ 2. $ _____ per mo. Company _____

E. ABSENT PARENT INFORMATION (Complete this section if a parent of any of the children is absent from the home.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE/ SEX	SOCIAL SECURITY NUMBER	BIRTHDATE	PARENT OF WHICH CHILD?	LAST KNOWN ADDRESS

Do you have a good reason for not cooperating in obtaining support for medical care? ☐ YES ☐ NO If yes, please explain. _____

F. PLEASE READ CAREFULLY AND SIGN BELOW

- I/we agree that I/we must provide Social Security Numbers of all persons applying for MC+ as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/we agree I/we must be evaluated for the Health Insurance Premium Payment Program (HIPP) if I or members of the household are employed or lost employment in the last 30 days and the employer or former employer offers group health insurance.
- I/we agree that my/our statements and information provided may be verified.
- I/we will report any changes in circumstances within TEN DAYS of when they happen.
- I/we know that it is against the law to obtain or attempt to obtain benefits to which I am/we are not entitled. Any false claim, statement, or concealment of any material fact whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- I/we agree that by applying for (and being determined eligible for) MC+ for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri, and that I/we must cooperate in establishing paternity and obtaining medical support, **unless I/we have good cause. Failure to cooperate does not affect a child's eligibility.**
- I/we understand healthcare benefits based on a person being age 65 and over, blind or disabled is not determined by completing this application. If I/we want eligibility for healthcare benefits explored on the basis of being age 65 or over, blind or disabled, I/we must complete a different application for these benefits.
- I/we agree that medical information about me and/or my family can be released if needed to administer this program.
- Provided I am/we are found to be eligible for MC+ I/we know the state of Missouri will pay for covered services on my/our behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.

My/our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my/our knowledge. I/we authorize insurers or employers to release any information on myself or my dependent(s) needed to determine eligibility for the HIPP program.

SIGNATURE/AFFIDAVIT	DATE	SIGNATURE OF SPOUSE/AFFIDAVIT	DATE